Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS4757HHA | A. BUILDING _____ B. WING _____ | 05/09/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| QUALITY HOME HEALTH, INC | 1641 E FLAMINGO ROAD, SUITE 13 LAS VEGAS, NV 89119 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| H 00 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as a result of an abbreviated focused State Relicensure Survey conducted at your agency on 5/9/11, in accordance with Nevada Administrative Code, Chapter 449 Home Health Agencies.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>The patient census was 10.<br>Three patient files were reviewed.<br>One patient phone interview was conducted.<br>Seven employee files were reviewed.<br><br>No regulatory deficiencies were found. | H 00 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE